BlueCross BlueShield of Illinois

BENEFIT PLAN SELECTION (BPS) - ACA SMALL GROUP

Please complete & return this form in its entirety, including the required signatures

Section 1- Account Information:

A. Employer Name:			B. SIC Code	
C. BlueSTAR Account #:		D. Effective Date:	E. Anniversary Date:	

- Only Individual cost shares are listed out for each plan.
- A group may select up to six health plan options.
- For additional product detail, please utilize Summary of Benefits and Coverage (SBC) and Product Plan Grids

Billing Method Selection
Please select one of the following billing methods.
(For Existing Accounts: If no selection is made, your plans will default to their current billing method.)
☐ Composite Billing
☐ Age Billing

Section 2a- Renewing Groups Only: (*New Business update to Section 4)

Current Plan: Please list current plan(s) below	Retaining Plan:		Replacing Plan: Please list replacement plan in space below.
1.	☐ **Yes**	☐ **No**	
2.	☐ **Yes**	☐ **No**	
3.	☐ **Yes**	☐ **No**	
4.	☐ **Yes**	☐ **No**	
5.	☐ **Yes**	☐ **No**	
6.	☐ **Yes**	☐ **No**	

Section 2b- Renewing Groups Only: (*New Business update to Section 4)

Adding Plan (Medical and/or Dental)**:**
Please list new plan(s) below

1.
2.
3.
4.
5.
6.

Section 3- HSA

HSA Vendor: *** If HSA is selected, a vendor will need to be selected.** (If no HSA selection is made, HSA Vendor will default to Other / None.)	☐ **Option A:** BenefitWallet® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option B:** HSA Bank® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option C:** FlexHSA® **Account Maintenance Fee:** ☐ **Employer Paid** ☐ **Employee Paid**
	☐ **Option D:** Other HSA Vendor / None (Select this option if using an HSA Vendor other than above or are not offering an employer sponsored HSA vendor.)

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Section 4- New Business

Group Number:

Please select plan designs (Up to a maximum of 6 plans)

A. PPO (Participating Provider Options)

2020 Plan ID	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay*4	Ped Dental (In/Out)*2	Non-Preferred Pharmacy**	Preferred Pharmacy
Platinum								
☐P5E1PPO*11	$500/$1000	$20/$40	90%/60%	$1500/Unlimited	$400	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐P503PPO*11	$250/$500	$30/$60	80%/50%	$1250/Unlimited	$400	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
Gold								
☐G530PPO*11	$3250/$6500	$15/$35	100%/100%	$3250/$6500	$400	100%/100%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G531PPO*11	$2500/$3000	$20/$60	80%/50%	$5000/Unlimited	$400	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G532PPO*11	$1500/$2500	$35/$60	80%/50%	$4500/Unlimited	$400	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐G534PPO*11	$750/$1500	$50/$70	80%/50%	$5500/Unlimited	$500	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐G536PPO*11	$2000/$4000	$30/$50	90%/60%	$4000/Unlimited	$400	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G537PPO*11	$2250/$4500	100%/100%	100%/100%	$2250/$4500	NA	100%/100%	100%	100%
Silver								
☐S501PPO*11	$4500/$9000	80%/80%	80%/50%	$7900/Unlimited	NA	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S531PPO*11	$4500/$9000	$30/$50	80%/50%	$8150/Unlimited	$500	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S532PPO*1*11	$2900/$5800	$50/$70	60%/50%	$7700/Unlimited	$500	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S535PPO*11	$7350/$14700	$20/$40	100%/100%	$7350/$14700	$500	100%/100%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250

PPO HSA Plans

2020 Plan ID	HSA Contr.	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay*4	Ped Dental (In/Out)*2	Non-Preferred Pharmacy**	Preferred Pharmacy
Gold									
☐G533PPO*11	$180-$535	$2800/ $5600	90%/90%	90%/ 60%	$3500/Unlimited	NA	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐G535PPO*11	$475-$890	$2800/ $5600	80%/80%	80%/ 50%	$5000/Unlimited	NA	70% 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
Silver									
☐S534PPO*11	$0-$200	$4800/ $9600	100%/100%	100%/ 100%	$4800/$9600	NA	100%/ 100%	100%	100%
Bronze									
☐B535PPO*11	$0	$6750/ $13500	100%/100%	100%/ 100%	$6750/$13500	$150	100%/ 100%	100%	100%
☐B536PPO*11	$0	$6500/ $13000	80%/80%	80%/ 50%	$6750/Unlimited	$150	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy then a lower copay may apply
*1 $500 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply.
*2 Ped Dental Out coinsurance is subjected to INN ded/coins.
*4 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.
*11 - Virtual Visits are available from a participating provider for certain non-emergency services.

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B. Blue Choice Preferred

2020 Plan ID	Deductible (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay[*4]	Ped Dental (In/Out)*2	Non-Preferred Pharmacy**	Preferred Pharmacy
Platinum								
☐P5E1BCE[*11]	$500/$1000	$20/$40	90%/60%	$1500/Unlimited	$400	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐P5E2BCE[*11]	$250/$500	$30/$60	80%/50%	$1250/Unlimited	$400	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
Gold								
☐G530BCE[*11]	$3250/$6500	$15/$35	100%/100%	$3250/$6500	$400	100%/100%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G531BCE[*11]	$2500/$3000	$20/$60	80%/50%	$5000/Unlimited	$400	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G532BCE[*11]	$1500/$2500	$35/$60	80%/50%	$4500/Unlimited	$400	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
Silver								
☐ S501BCE[*11]	$4500/$9000	80%/80%	80%/50%	$7900/Unlimited	NA	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S531BCE[*11]	$4500/$9000	$30/$50	80%/50%	$8150/Unlimited	$500	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S532BCE[*1*11]	$2900/$5800	$50/$70	60%/50%	$7700/Unlimited	$500	70%/50%	$10/$20/$70/$120/$150/$250	$0/$10/$50/$100/$150/$250
☐S535BCE[*11]	$7350/$14700	$20/$40	100%/100%	$7350/$14700	$500	100%/100%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250

Blue Choice Preferred HSA Plans

2020 Plan ID	HSA Contr.	Deduct (In/Out)	Office Visit/ Specialist	Coins (In/Out)	OPX (In/Out)	ER Copay	Ped Dental (In/Out)*2	Non-Preferred Pharmacy**	Preferred Pharmacy
Gold									
☐G533BCE[*11]	$180-$535	$2800/ $5600	90%/90%	90%/ 60%	$3500/Unlimited	NA	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
☐G535BCE[*11]	$475-$890	$2800/ $5600	80%/80%	80%/ 50%	$5000/Unlimited	NA	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%
Silver									
☐S534BCE[*11]	$0-$200	$4800/ $9600	100%/100%	100%/ 100%	$4800/$9600	NA	100%/ 100%	100%	100%
Bronze									
☐B535BCE[*11]	$0	$6750/ $13500	100%/100%	100%/ 100%	$6750/$13500	$150	100%/ 100%	100%	100%
☐B536BCE[*11]	$0	$6500/ $13000	80%/80%	80%/ 50%	$6750/Unlimited	$150	70%/ 50%	80%/80%/70%/60%/60%/50%	90%/90%/80%/70%/60%/50%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.

**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy, then a lower copay may apply.

*1 $500 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply.

*2 Ped Dental Out coinsurance is subjected to INN ded/coins.

*4 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.

*11 - Virtual Visits are available from a participating provider for certain non-emergency services.

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C. Blue Options

Tiered Network (Blue Options – BCO / PPO – PPO / OON – Out of Network)

2020 Plan ID	Deductible (BCO/ PPO/ OON	PCP Copay (BCO/ PPO)	SPC Copay (BCO/ PPO)	Coins (BCO /PPO/ OON)	OPX (BCO/ PPO/ OON)	ER Copay[*4]	Ped Dental (In/Out)[*2]	Non-Preferred Pharmacy**	Preferred Pharmacy
				Gold					
☐G506OPT[*11]	$750/ $1750/ $3500	$30/ $60/	$60/ $100	80%/ 70%/ 50%	$4450/ $6250/ Unlimited	$500	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G507OPT[*11]	$2000/ $3500/ $7000	$35/ $60	$50/ $100	90%/ 70% 50%	$3500/ $6500/ Unlimited	$400	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
☐G508OPT[*11]	$1500/ $3000/ $6000	$15/ $40	$30/ $80	90%/ 70%/ 50%	$3000/ $5000/ Unlimited	$400	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250
				Silver					
☐S506OPT[*11]	$4500/ $5500/ $11000	$30/ $60	$60/ $100	80%/ 60%/ 50%	$6500/ $8150/ Unlimited	$500	70%/50%	$10/$20/$55/$95/$150/$250	$0/$10/$35/$75/$150/$250

Blue Options HSA Plans

2020 Plan ID	HSA Cont.	Deductible (BCO/ PPO/ OON	PCP Copay (BCO/ PPO)	SPC Copay (BCO/ PPO)	Coins (BCO /PPO/ OON)	OPX (BCO/ PPO/ OON)	ER Copay	Ped Dental (In/Out)[*2]	Non-Preferred Pharmacy**	Preferred Pharmacy
					Silver					
☐S507OPT[*11]	$0- $125	$4000/ $4750/ $9500	100%/ 80%	100%/ 80%	100%/ 80%/ 50%	$4000/ $6550/ Unlimited	NA	70%/ 50%	100%	100%

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy then a lower copay may apply
*2 Ped Dental Out coinsurance is subjected to INN ded/coins.
*4 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.
*11 Virtual Visits are available from a participating provider for certain non-emergency services.

D. Blue Precision HMO

2020 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay[*4]	Ped Dental (In)	Non-Preferred Pharmacy**	Preferred Pharmacy
				Platinum				
☐P506PSN[*5*6*8]	$0	$10/$45	100%	$1500	$300	100%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐P5E1PSN[*5*6*8]	$1000	$25/$50	80%	$3000	$400	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
				Gold				
☐G532PSN[*2*6*8*9]	$2500	$40/$60	70%	$6750	$700	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐G533PSN[*2*6*8*9]	$4000	$30/$50	70%	$7900	$400	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
				Silver				
☐S530PSN[*1*6*8*10]	$6500	$40/$60	70%	$7400	$700	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐S531PSN[*3*7*8]	$3000	$35/$55	80%	$7900	$1000	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.
**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy, then a lower copay may apply
*1 - $350 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply.
*2 - No deductible/coinsurance on capitated services: Imaging, Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.
*3 - $750 copay on Imaging (CT/PET/MRI) $250 copay on other capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient surgery.
*4- ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.
*5 - $250 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs). $45 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.
*6 - Urgent Care is covered at the Office Visit copay amount. PCP vs Specialist is dependent on provider type billed.
*7 - Urgent Care is covered at the Office Visit copay amount. PCP vs Specialist is dependent on provider type billed. Per occurrence Emergency Room/Out Patient Inpatient true copay per day is $750 on Imaging (CT/PET/MRI).
*8 - Ped Dental Out coinsurance is subjected to INN ded/coins.
*9 - INN Mental health/substance abuse Office Visits always covered at $0/no charge.
*10 - $60 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.

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E. BlueCare Direct HMO

2020 Plan ID	Deductible (In)	Office Visit/ Specialist	Coins (In)	OPX (In)	ER Copay*4	Ped Dental (In)	Non-Preferred Pharmacy**	Preferred Pharmacy
Platinum								
☐P5E1BCH*2*6*8*9	$1000	$25/$50	80%	$3000	$400	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐P506BCH*3*5*6*8	$0	$10/$45	100%	$1500	$300	100%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
Gold								
☐G532BCH*2*6*8*9	$2500	$40/$60	70%	$6750	$700	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐G533BCH*2*6*8*9	$4000	$30/$50	70%	$7900	$400	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
Silver								
☐S530BCH*1*6*8*10	$6500	$40/$60	70%	$7400	$700	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
☐S532BCH*7*8*11	$3000	$35/$55	80%	$7900	$1000	70%	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250

All health plans are embedded with pediatric eye exams (and select pediatric hardware) and vision discounts.

**The prescription benefits outlined above are the non-preferred copays. If a member goes to a preferred pharmacy then a lower copay may apply

*1 $350 copay on Imaging (CT/PET Scans, MRIs), deductible and coinsurance do not apply.

*2 No deductible/coinsurance on capitated services: Imaging, Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.

*3 $250 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs

*4 ER copays are per-occurrence deductibles, member is responsible for the listed copay amount and the rest of the billable charge is subject to deductible and coinsurance.

*5 $250 copay and no deductible/coinsurance on Imaging (CT/PET Scans, MRIs). $45 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.

*6 Urgent Care is covered at the Office Visit copay amount. PCP vs Specialist is dependent on provider type billed.

*7 Urgent Care is covered at the Office Visit copay amount. PCP vs Specialist is dependent on provider type billed. Per occurrence Emergency Room/Out Patient Inpatient true copay per day is $750 on Imaging (CT/PET/MRI).

*8 - Ped Dental Out coinsurance is subjected to INN ded/coins.

*9 - INN Mental health/substance abuse Office Visits always covered at $0/no charge.

*10 - $60 copay and no deductible/coinsurance on capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient Surgery.

*11- $750 copay on Imaging (CT/PET/MRI) $250 copay on other capitated services: Rehabilitative Speech/Occupational/Physical Therapy, Laboratory services, X-rays and Diagnostic Imaging, Outpatient surgery.

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Section 5- Ancillary Product Selection:

A. Dental Products

1. Blue Care Dental

Plan Pairings (Groups 10+ enrolled)		Participation Requirements	
Contributory Group	**Voluntary**	**Contributory Group**	**Voluntary**
High Option: DILHR01, DILHR02, DILHR03*, DILHR04, DILHM08, DILHM10, DILHR20, DILHM27* **Low Option**: DILLR06, DILLR07, DILLM11, DILLM21, DILLR28 *DILHR03 and DILHM27 may be paired. Any one contributory high option can be paired with any one contributory group low option; **DILHM12** can be freely paired with any contributory group.	**High Option**: DILHR13, DILHM14, DILHR22, DILHR23, DILHM29** **Low Option**: DILLR24, DILLM25, DILLM26, DILLR30 **DILHR13 and DILHM29 may be paired. Any one voluntary high option can be paired with any one voluntary low option; **DILHM16** can be freely paired with any voluntary option.	>70% Participation >50% Employer contribution	>25% Participation Employers are not required to contribute to Voluntary Dental plans

IL Plan ID	Plan Type	Deductible (In/Out) (3x Family Limit)	Annual Benefit Max	Out-of-Network Reimb.	Coinsurance: In-Network (Class I/ II/ III/ IV)	Coinsurance: Out-of-Network (Class I/ II/ III/ IV)	Ortho Life Maximum	Allocation
Contributory Group[*2]								
☐ DILHR01	Passive	$25/$25	$3000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000	High
☐ DILHR02	Passive	$50/$50	$2000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$2000	High
☐ DILHR03	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500	High
☐ DILHR04	Active	$50/$75	$1500/$1000	90th R&C	100%/80%/50%/50%	80%/60%/50%/50%	$1000	High
☐ DILHM08	Passive	$50/$50	$1000	MAC	100%/80/50%/50%	100%/80%/50%/50%	$1000	High
☐ DILHM10	Active	$50/$50	$1500/$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	NA	High
☐ DILHM12[*3]	Passive	$25/$75	$750	MAC	100%/80[*3]/NA/NA	100%/80%[*3]/NA/NA	NA	High
☐ DILHR20	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	High
☐ DILHM27	Passive	$50/$50	$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	$1500	High
☐ DILLR06	Passive	$50/$50	$1000	90th R&C	100%/80/50%/NA	100%/80%/50%/NA	NA	Low
☐ DILLR07	Passive	$75/$75	$1000	90th R&C	90%/70%/50%/NA	90%/70%/50%/NA	NA	Low
☐ DILLM11	Active	$75/$75	$1000	MAC	90%/70%/50%/NA	70%/50%/30%/NA	NA	Low
☐ DILLM21	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
☐ DILLR28[*4]	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
Voluntary[*2]								
☐ DILHR13[*1]	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1500	High
☐ DILHM14[*1]	Active	$50/$50	$1500/$1000	MAC	100%/80%/50%/NA	80%/60%/40%/NA	NA	High
☐ DILHM16	Passive	$25/$75	$750	MAC	100%/80%[*3]/NA/NA	100%/80%[*3]/NA/NA	NA	High
☐ DILHR22[*1]	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000	High
☐ DILHR23[*1]	Passive	$50/$50	$1500	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	High
☐ DILHM29[*1]	Passive	$50/$50	$1500	MAC	100%/100%/60%/50%	100%/100%/60%/50%	$1500	High
☐ DILLR24[*1]	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/NA	100%/80%/50%/NA	NA	Low
☐ DILLM25[*1]	Passive	$50/$50	$1000	MAC	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low
☐ DILLM26[*1]	Active	$50/$100	$750	MAC	100%/80%/50%/NA	100%/50%/50%/NA	NA	Low
☐ DILLR30[*1*4]	Passive	$50/$50	$1000	90th R&C	100%/80%/50%/50%	100%/80%/50%/50%	$1000	Low

Coinsurance Type - I: Exams/Cleanings/X-Rays (both High & Low Coverage).
Coinsurance Type - II: Fillings/Non-Surgical Perio/Non-Surgical Extractions (both High & Low), Endo/Perio/Oral Surgery (High).
Coinsurance Type - III: Inlays/Onlays/Crowns/Dentures (both High & Low), Endo/Perio/Oral Surgery (Low).
Coinsurance Type - IV: Ortho (both High & Low Coverage).
R&C: Reasonable & Customary, MAC: Maximum Allowable Charge.
*1 Waiting Period 12 month applicable for Surgical Perio/Major Restorative/Prosthodontics/Misc Rest & Prosth Services.
*2 Waived Deductible applies to all Class I services and plans include 3x Family Deductible Limit.
*3 Only Basic Restorative Services are covered.
*4 - Prev/Diag svcs do not count toward annual max.

B. Life Products

If Life is a desired benefit, the Group Term Life product must be selected to also select Dependent Life and Short-Term Disability.

1. Group Term Life / Accidental Death & Dismemberment (AD&D)

☐ **Yes** ☐ **No**	Complete Item 4 below if Term Life benefits vary by class
Choose a Benefit:	**Choose a Reduction Method:**
☐ Flat Benefit of **$_______** per Employee	(Only available to groups with 10 or more enrolled lives) ☐ 35% of the original amount at age 65 / 50% of the original amount at age 70
☐ _______ times Basic Annual Salary (rounded to the next higher multiple of $1,000, if not already a multiple), up to a Maximum benefit of **$_______** per Employee	☐ 50% of the original amount at age 70
	(Only applicable to groups with 2 - 9 enrolled lives) ☐ 35% of the original amount at age 65, 50% of the original amount at age 70, 75% of the original amount at age 75, 85% of the original amount at age 80.

Excess Amounts of Life Insurance:

Evidence of Insurability will be required for individual life insurance amounts in excess of **$_______**. Such excess insurance amounts shall become effective on the date Evidence of Insurability is approved. Waiver of Premium, in the event of total disability, will terminate at age 65 or when no longer disabled, whichever is earlier. Being Actively at Work is a requirement for coverage. If an employee is not Actively at Work on the day coverage would otherwise be effective, the effective date of coverage will be the date of return to Active Work. If an employee does not return to Active Work, he/she will not be covered

2. Dependent Life

☐ **Yes** ☐ **No**		**Spouse**	**Children** – age birth to 14 days	**Children** – age 14 days to 6 months	**Children** – age 6 months to 26 years / students 26
Choose a Plan:	☐ Option1	$10,000	$100	$100	$5,000
	☐ Option 2	$5,000	$100	$100	$5,000
	☐ Option 3	$5,000	$100	$100	$2,000

3. Short Term Disability (STD)

☐ **Yes** ☐ **No**	Complete Item 4 below if Short Term Disability benefits vary by class (3 Max 2 – 9 lives) (6 Max 10+ lives) Benefit will not exceed 66 2/3% of Basic Weekly Salary and is payable for non-occupational disabilities only		
Choose a Benefit:			
☐ Flat **$_____** weekly (not to exceed $250)			
☐ Salary Based (select one) -	☐ 50%	☐60%	☐ 66 2/3% of Basic Weekly Salary up to a maximum of **$_____**

Choose a Plan: Accident/Sickness/Duration

☐ 1 / 8 / 13 weeks ☐ 8 / 8 / 13 weeks ☐ 15 / 15 / 13 weeks	*☐ 31 / 31 / 13 weeks *Only available to groups with 10 or more lives enrolled
☐ 1 / 8 / 26 weeks ☐ 8 / 8 / 26 weeks ☐ 15 / 15 / 26 weeks	*☐ 31 / 31 / 26 weeks

4. Classes

Please complete this chart if Term Life or Short Term Disability benefits vary by class

Class Description	Term Life / AD&D	Short Term Disability

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Section 6 - Additional Provisions:

Use this section to indicate if the account is retaining any plan(s) not shown above or need to indicate any other instruction or important information.

Section 7 - Signature

Signatures	
Employer / Authorized Purchaser: Title:	Date
Underwriter: Title:	Date

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